(d) The rate for capital costs shall be determined as follows:

(i) The initial rate shall be determined under PARAGRAPHS (A) AND (B) OF rule 5101:3-3-51 of the Administrative Code using THE GREATER OF an imputed occupancy rate of eighty per cent OR THE ESTIMATED INPATIENT DAYS and the costs reported in a three-month projected cost report beginning the first day of medicaid participation, subject to the limitation under rule 5101:3-3-51 of the Administrative Code for the fiscal year in which the rate will be paid. The three-month projected cost report shall include schedules A, A-1, D, and D-1 of the ODHS 2524 medicaid cost report for NFs and intermediate care facilities for the mentally retarded (ICFs-MR). ODHS shall begin to pay the rate based on the three-month projected cost report one month after the first day of the month after the department receives the report. In the event the NF does not submit a three-month projected cost report, the NF shall be assigned the median capital rate of all NFs as calculated at the beginning of the fiscal year in which the rate will be paid under rule 5101:3-3-51 of the Administrative Code.

(ii) After the NF files its three-month cost report under rule 5101:3-3-20 of the Administrative Code, the rate shall be the lesser of the desk-reviewed, actual, allowable, per diem capital costs from the three-month cost report or the limitation determined under rule 5101:3-3-51 of the Administrative Code for the fiscal year in which the rate will be paid.

(e) Rates based upon data from the three-month cost report filed under rule 5101:3-3-20 of the Administrative Code, as calculated under paragraphs (A)(1)(a) to (A)(1)(d) of this rule shall be effective starting the first day of the calendar quarter that begins more than ninety days after ODHS receives the cost report. IF THE THREE MONTH COST REPORT IS FILED AFTER THE NINETY DAY DUE DATE AND THIS REPORT RESULTS IN A LOWER RATE, THE RATE SHALL BE EFFECTIVE ON THE FIRST DAY OF THE CALENDAR QUARTER FOLLOWING ONE-HUNDRED AND EIGHTY DAYS AFTER THE END OF THE COST REPORTING PERIOD.

(2) After the end of the fiscal year in which the NF began participation in the medical assistance program, the rates for the second fiscal year and subsequent fiscal years shall be set using the NF's cost report filed under rule 5101:3-3-20 of the Administrative Code for the full calendar year preceding the fiscal year in which the rate will be paid and the provisions of rules 5101:3-3-44, 5101:3-3-49, 5101:3-3-50, and 5101:3-3-51 of the Administrative Code. If the NF did not file a cost report for the full calendar year preceding the fiscal year, ODHS shall use the following principles to set the rate for the second fiscal year:

(a) If the NF was not required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the NF began participation in the medical assistance program October second of that calendar year or later, the rate shall be determined under paragraph (A)(1) of this rule.

(b) If the NF was required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the NF began participation in the medical assistance program October first of that calendar year or earlier, the rate shall be determined under rules 5101:3-3-44, 5101:3-3-49, 5101:3-3-50, and 5101:3-3-51 of the Administrative Code, except as follows:

(i) The inflation rate used to inflate the NF's desk reviewed, actual, allowable per diem cost shall be determined by using the midpoint of the cost report period to the midpoint of the fiscal year in which the rate will be paid to calculate a prorated portion of the eighteen-month inflation rate determined for each applicable cost center for the fiscal year. Capital costs are not inflated.

(ii) The NF's actual CPCMU is determined by dividing the NFs desk-reviewed, actual, allowable, per diem direct care costs from the partial calendar year cost report by the NF's actual case-mix score(s) for the reporting quarter or quarters that ended during the cost report period. Until the facility submits assessment information that qualifies for use in calculating an actual case-mix score(s), ODHS shall use the median CPCMU for the facility as prescribed by paragraph (A)(1)(a)(i) of this rule.

(c) If the NF was not required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the NF began participation in the medical assistance program after the end of the calendar year, the rate shall be determined under paragraph (A)(1) of this rule.

(B) The ODHS shall determine rates for a NF provider that changes provider agreements as set forth under rule 5101:3-3-516 of the Administrative Code within the existing building in the following manner:

(1) For the fiscal year in which change of provider agreement occurs, the new provider's initial rate shall be the same rate and ~~methodology~~ METHOD OF CALCULATION as the previous provider, except as follows:

(a) The new provider may request a change in its capital rate under rule 5101:3-3-24 of the Administrative Code.

(b) After the new provider files its three-month cost report under paragraph (E)(1)(d) of rule 5101:3-3-20 of the Administrative Code, the rate shall be determined under rules 5101:3-3-44, 5101:3-3-49, 5101:3-3-50, and 5101:3-3-51 of the Administrative Code using the costs reported on the three-month cost report, except as follows:

(i) The inflation rate used to inflate the new provider's desk-reviewed, actual, allowable per diem cost reported on the three-month cost report shall be determined by using the midpoint of the cost report period to the midpoint of the fiscal year in which the rate will be paid to calculate a prorated portion of the eighteen-month inflation rate determined for each applicable cost center for that fiscal year. Capital costs are not inflated.

(ii) The new provider's actual CPCMU shall be calculated by dividing the actual, allowable, per diem direct care costs reported on the three-month cost report by the new provider's actual case-mix score(s) for the reporting quarter or quarters that ends during the cost report period. Until the new provider submits assessment information that qualifies for use in calculating an actual case-mix score(s), ODHS shall use the median CPCMU for the facility as prescribed by paragraph (A)(1)(a)(i) of this rule.

The rate calculated based upon the three-month cost report shall be effective starting the first day of the calendar quarter that begins more than ninety days after ODHS receives the cost report.

(2) After the end of the fiscal year in which the change of provider agreement occurred, the rates for the second fiscal year and subsequent fiscal years shall be set using the new provider's cost report filed under rule 5101:3-3-20 of the Administrative Code for the full calendar year preceding the fiscal year in which the rate will be paid and the provisions of rules 5101:3-3-44, 5101:3-3-49, 5101:3-3-50, and 5101:3-3-51 of the Administrative Code. ~~If the new provider did not file a cost report for the full calendar year preceding the fiscal year, ODHS shall use the following principles to set their rate for the second fiscal year:~~

~~(a) If the new provider was not required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the change of provider agreement occurred October second of that calendar year or later, the rate shall be the same as the rate that was in effect at the end of the preceding fiscal year adjusted by the inflation rates determined for the fiscal year under rules 5101:3-3-44, 5101:3-3-49, and 5101:3-3-50 of the Administrative Code. The rate shall be adjusted as provided in paragraphs (B)(1)(a) and (B)(1)(b) of this rule.~~

~~(b)~~(a) If the new provider was required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the change of provider agreement occurred October first of that calendar year or earlier, the rate shall be determined under rules 5101:3-3-44, 5101:3-3-49, 5101:3-3-50, and 5101:3-3-51 of the Administrative Code except as follows:

(i) The inflation rate used to inflate the new provider's desk-reviewed, actual, allowable per diem cost reported on the calendar year ending cost report shall be determined by using the midpoint of the cost report period to the midpoint of the fiscal year in which the rate will be paid to calculate a prorated portion of the eighteen-month inflation rate determined for each applicable cost center for that fiscal year. Capital costs are not inflated.

(ii) The CPCMU shall be calculated by dividing the actual, allowable, per diem direct care costs reported on the partial calendar year ending cost report by the actual case mix score(s) for the reporting quarter or quarters that ended during the cost report period. Until the new provider submits assessment information that qualifies for use in calculating an actual case-mix score(s). ODHS shall use the median CPCMU for the facility as prescribed by paragraph (A)(1)(a)(i) of this rule.

~~(c)~~ (b) If the new provider was not required to file a calendar year ending cost report pursuant to rule 5101:3-3-20 of the Administrative Code for the calendar year preceding the fiscal year in which the rate will be paid because the ~~new provider changed provider agreements~~ CHANGE OF PROVIDER AGREEMENT OCCURRED OCTOBER SECOND OF THAT CALENDAR YEAR OR LATER OR after the end of the calendar year, the rate shall be the same as the rate that was in effect at the end of the preceding fiscal year adjusted by the inflation rates determined for the fiscal year under rules 5101:3-3-44, 5101:3-3-49, and 5101:3-3-50 of the Administrative Code. The rate shall be adjusted as provided in paragraphs (B)(1)(a) and (B)(1)(b) of this rule.

(3) The provisions set forth under paragraph (B) of this rule do not apply to NFs which are new to the medical assistance program as defined under paragraph (A) of this rule, including NFs which receive a new license based upon the relocation of BEDS FROM EXISTING NFS ~~one or more replaced facilities~~ in operation immediately before the opening of the new NF. The rates for these NFs are calculated under paragraph (A) of this rule, AS REPLACEMENT FACILITIES.

Effective Date: _____

Review Date: _____

Certification: _____

_____
Date

Promulgated Under: Chapter 119.
Statutory Authority: RC Section 5111.02
Rule Amplifies: RC Sections 5111.01, 5111.02, 5111.25, 5111.255
Prior Effective Dates: 7/1/93 (Emer.), 9/30/93, 6/30/94 (Emer.), 1/1/95

TN #98-19 APPROVAL DATE MAR 15 1999
SUPERSEDES
TN #95-02 EFFECTIVE DATE 12/17/98

101:3-3-56 NURSING FACILITIES (NFS): NONREIMBURSABLE ~~Nonreimbursable~~ costs ~~for nursing facilities (NFs)~~.

The following costs are not reimbursable to NFs through the prospective reimbursement cost reporting mechanism. ~~Except~~ EXCEPT as ~~otherwise~~ specified under Chapter 5101:3-3 of the Administrative Code, nonreimburseable costs include but are not limited to:

(A) Fines or penalties paid under sections 5111.28, 5111.35 to 5111.62, and 5111.99 of the Revised Code.

(B) Disallowances made during ~~fiscal~~ THE audit of the NF's cost report which are sanctioned through adjudication in accordance with Chapter 119. of the Revised Code.

(C) Costs which exceed prudent buyer tests of reasonableness which may be applied pursuant to the provisions of the "Provider Reimbursement Manual," health care financing administration (HCFA) publication 15-1, during ~~fiscal~~ THE audit of the NF's cost report.

(D) The costs of physical ~~therapy~~, occupational ~~therapy~~, ~~audiology~~, and speech ~~therapy~~ THERAPIES ~~services~~ provided by appropriately licensed therapists or therapy assistants. THE COST OF SERVICES PROVIDED BY AN APPROPRIATELY LICENSED AUDIOLOGIST. This does not apply to maintenance ~~therapy~~ THERAPIES ~~services~~ provided by nursing staff as set forth in rule 5101:3-3-46 of the Administrative Code.

(E) The costs of ancillary services rendered to NF residents by providers who bill medicaid directly. ~~These~~ ANCILLARY services include but are not limited to: physicians, legend drugs, radiology, laboratory, oxygen, and resident-specific medical equipment.

(F) Cost per case-mix units in excess of the applicable ~~maximum~~ PEER GROUP ~~costs~~ CEILING ~~per case-mix units~~ FOR DIRECT CARE COST set forth in rule 5101:3-3-44 of the Administrative Code.

(G) ~~Costs~~ EXPENSES in excess of the APPLICABLE ~~indirect care~~ PEER GROUP ~~costs~~ ceiling FOR INDIRECT CARE COST set forth in rule 5101:3-3-50 of the Administrative Code.

(H) ~~Costs~~ EXPENSES in excess of the capital costs limitations set forth in rule 5101:3-3-51 of the Administrative Code.

(I) Purchased nursing services ~~in excess of percentages~~ THAT EXCEED THE PERCENTAGES set forth in rule 5101:3-3-45 of the Administrative Code.

(J) ~~Costs~~ EXPENSES associated with lawsuits filed against the Ohio department of human services which are not upheld by the courts.

(K) COST OF MEALS SOLD TO VISITORS OR PUBLIC (I.E., MEALS ON WHEELS).

(L) COST OF SUPPLIES OR SERVICES SOLD TO NONFACILITY RESIDENTS OR PUBLIC.

(M) COST OF OPERATING A GIFT SHOP.

Effective Date: _____

Review Date: _____

Certification: _____

_____
Date

Promulgated under: RC Chapter 119.
Statutory authority: RC Section 5111.02
Rule amplifies: RC Sections 5111.01, 5111.02, 5111.23 To 5111.28, 5111.35 To 5111.62, 5111.99
Prior effective dates: 12/30/77, 8/3/79, 7/1/80, 1/1/84, 7/1/88 (Emer.), 9/25/88, 12/30/88 (Emer.), 3/31/89 (Emer.), 6/18/89, 10/1/89, 12/20/91, 9/30/93 (Emer.), 1/1/94

5101:3-3-518 ASSETS ACQUIRED JANUARY 1, 1993 TO JUNE 30, 1993 FOR NURSING FACILITIES (NFS).

THE DEPARTMENT OF HUMAN SERVICES (ODHS) SHALL INCLUDE THE ACTUAL, ALLOWABLE CAPITAL COST BASIS OF ASSETS CONSTRUCTED OR ACQUIRED DURING THE PERIOD BEGINNING JANUARY 1, 1993, AND ENDING JUNE 30, 1993, IN THE CALCULATION FOR THE NF'S RATE EFFECTIVE JULY 1, 1993, IF THE AGGREGATE CAPITAL COSTS OF THE ASSETS WOULD INCREASE THE NF'S RATE BY TWENTY OR MORE CENTS PER RESIDENT PER DAY AND THE NF PROVIDES ODHS WITH SUFFICIENT DOCUMENTATION OF THE COSTS BEFORE JUNE 1, 1993. IF THE NF PROVIDES THE DOCUMENTATION AFTER THAT DATE, ODHS SHALL ADJUST THE NF'S RATE TO REFLECT THE COSTS OF THE ASSETS ONE MONTH AFTER THE FIRST DAY OF THE MONTH AFTER ODHS RECEIVES THE DOCUMENTATION.

(A) EXCEPT AS PROVIDED UNDER RULE 5101:3-3-24 OF THE ADMINISTRATIVE CODE, FOR A NF THAT QUALIFIES FOR A RATE ADJUSTMENT SOLELY BECAUSE OF ASSETS ACQUIRED THROUGH A CHANGE OF OWNERSHIP OF THE NF, ADDITION OF BEDS TO THE NF, OR A SINGLE RENOVATION OR REPLACEMENT OF BEDS, ODHS SHALL CALCULATE THE RATE ADJUSTMENT AS FOLLOWS:

(1) FOR ASSETS ACQUIRED FROM JANUARY 1, 1993, TO JUNE 30, 1993, CALCULATE THE DEPRECIATION AND INTEREST EXPENSE INCURRED THROUGH JUNE 30, 1993.

(2) CALCULATE THE GREATER OF THE NF'S INPATIENT DAYS FOR THAT PERIOD OR THE NUMBER OF INPATIENT DAYS THE NF WOULD HAVE HAD DURING THAT PERIOD IF ITS OCCUPANCY RATE HAD BEEN NINETY-FIVE PER CENT. FOR PURPOSES OF PARAGRAPH (A) OF THIS RULE, THAT TIME PERIOD REFERS TO THE TIME PERIOD BETWEEN THE CHANGE OF OWNERSHIP OR PLACEMENT INTO SERVICE OF THE ADDITIONAL BEDS OR RENOVATED SPACE AND JUNE 30, 1993.

(3) FOR PURPOSES OF CALCULATING A PER DIEM EXPENSE DIVIDE THE DEPRECIATION AND INTEREST EXPENSE UNDER PARAGRAPH (A)(1) OF THIS RULE BY THE INPATIENT DAYS UNDER PARAGRAPH (A)(2) OF THIS RULE.

(4) RECALCULATE THE ENTIRE CAPITAL RATE UNDER RULE 5101:3-3-51 OF THE ADMINISTRATIVE CODE TO DETERMINE IF THE NF'S RATE INCREASED BY TWENTY OR MORE CENTS PER RESIDENT PER DAY

(B) ANY OTHER NF THAT QUALIFIES FOR A RATE ADJUSTMENT FOR ASSETS ACQUIRED BETWEEN JANUARY 1, 1993, AND JUNE 30, 1993, ODHS SHALL CALCULATE THE RATE ADJUSTMENT AS FOLLOWS:

(1) FOR ASSETS ACQUIRED FROM JANUARY 1, 1993, TO JUNE 30, 1993, CALCULATE THE DEPRECIATION AND INTEREST EXPENSE INCURRED THROUGH JUNE 30, 1993.

(2) CALCULATE THE GREATER OF THE NF'S INPATIENT DAYS FOR THAT PERIOD OR THE NUMBER OF INPATIENT DAYS THE NF WOULD HAVE HAD DURING THAT PERIOD IF ITS OCCUPANCY RATE HAD BEEN NINETY-FIVE PER CENT. FOR PURPOSES OF PARAGRAPH (B) OF THIS RULE, THAT TIME PERIOD REFERS TO THE DATE THE FIRST ASSET WAS ACQUIRED AND JUNE 30, 1993.

(3) FOR PURPOSES OF CALCULATING A PER DIEM EXPENSE DIVIDE THE DEPRECIATION AND INTEREST EXPENSE UNDER PARAGRAPH (B)(1) OF THIS RULE BY THE INPATIENT DAYS UNDER PARAGRAPH (B)(2) OF THIS RULE.

(4) RECALCULATE THE ENTIRE CAPITAL RATE UNDER RULE 5101:3-3-51 OF THE ADMINISTRATIVE CODE TO DETERMINE IF THE NF'S RATE INCREASED BY TWENTY OR MORE CENTS PER RESIDENT PER DAY.

REPLACES RULE 5101:3-3-22

EFFECTIVE DATE: _____

CERTIFICATION: _____

_____

PROMULGATED UNDER: RC CHAPTER 119.
STATUTORY AUTHORITY: RC SECTION 5111.02
RULE AMPLIFIES: RC SECTIONS 5111.01, 5111.02, 5111.25
PRIOR EFFECTIVE DATES: 7/3/80, 9/1/82, 2/21/83, 8/15/83 (EMER.), 11/10/83 (EMER.), 12/25/83, 2/12/85 (EMER.), 6/1/85, 8/1/87, 9/30/87 (EMER.), 12/28/87, 10/1/91 (EMER.), 12/20/91, 9/30/93 (EMER.)

TNS # 94-057 APPROVAL DATE JUN 28 1994
SUPERSEDES
TNS # 92-024 EFFECTIVE DATE 10/1/94

FILED
JUN 2 0 1997
L.S.C.

5101:3-3-59 COVERAGE OF BED-HOLD DAYS FOR MEDICALLY NECESSARY AND OTHER LIMITED ABSENCES IN NURSING FACILITIES (NFS).

(A) DEFINITIONS:

(1) "ADMISSION" MEANS AN INDIVIDUAL WHO WAS NOT CONSIDERED TO BE A RESIDENT OF ANY OHIO MEDICAID-CERTIFIED NF IMMEDIATELY PRECEDING THE CURRENT NF ADMISSION INCLUDING ANY INDIVIDUAL WHO WAS FORMERLY A NF RESIDENT BUT WHO EXHAUSTED THEIR BED-HOLD DAYS WHILE IN THE COMMUNITY AND/OR HOSPITAL STAY. ADMISSIONS ARE DISTINGUISHED FROM RETURNS OF RESIDENTS ON BED-HOLD STATUS.

(2) "BED-HOLD DAYS," ALSO REFERRED TO AS "LEAVE DAYS," ARE THE SPAN OF TIME THAT A BED IS RESERVED FOR THE RESIDENT, THROUGH MEDICAID VENDOR PAYMENT, WHILE THE RESIDENT IS OUTSIDE THE FACILITY FOR HOSPITAL STAYS, VISITATIONS WITH FRIENDS AND RELATIVES, OR PARTICIPATION IN THERAPEUTIC PROGRAMS AND HAS THE INTENT TO RETURN TO THAT FACILITY. A RESIDENT ON BED-HOLD DAYS HAS NOT BEEN DISCHARGED FROM THE FACILITY SINCE THE FACILITY IS REIMBURSED TO HOLD THE BED WHILE THE RESIDENT IS ON LEAVE. A PERSON ON DISCHARGED STATUS CAN NOT SIMULTANEOUSLY BE ON BED-HOLD STATUS.

(3) "CFR" MEANS CODE OF FEDERAL REGULATIONS, A CODIFICATION OF THE GENERAL AND PERMANENT RULES PUBLISHED IN THE FEDERAL REGISTER BY THE EXECUTIVE DEPARTMENTS AND AGENCIES OF THE FEDERAL GOVERNMENT.

(4) "DISCHARGE" MEANS THAT A RESIDENT LEAVES A NF AND DOES NOT INTEND TO RETURN TO THAT FACILITY. THE DISCHARGE MAY BE DUE, BUT NOT LIMITED, TO A TRANSFER TO ANOTHER FACILITY, THE EXHAUSTION OF BED-HOLD DAYS, THE RESIDENT'S DECISION TO RESIDE IN A COMMUNITY-BASED SETTING, OR DEATH OF THE RESIDENT.

(5) "HOME AND COMMUNITY-BASED SERVICES" (HCBS) MEANS SERVICES FURNISHED UNDER 42 CFR SECTION 440.180 AND UNDER THE PROVISIONS OF 42 CFR SUBPART G AND SPECIFIC OHIO PROGRAMS SET FORTH IN RULE 5111: 3-1-06 OF THE ADMINISTRATIVE CODE WHICH PERMIT INDIVIDUALS TO LIVE IN A HOME SETTING RATHER THAN A NF OR HOSPITAL. THESE SERVICES ARE SOMETIMES REFERRED TO AS "WAIVER" SERVICES OR AS 1915(c) PROGRAMS. A DESCRIPTION OF ALL OF OHIO'S WAIVER PROGRAMS IS LISTED IN RULE 5101:3-1-06 OF THE ADMINISTRATIVE CODE.

(6) "HOSPITALIZATION" REFERS TO A TRANSFER OF A RESIDENT TO A MEDICAL INSTITUTION AS DEFINED IN 42 CFR CHAPTER IV SECTION 435.1009.

(7) "INSTITUTIONS FOR MENTAL DISEASES" (IMDS) HAS THE SAME MEANING AS STATED IN RULE 5101:3-3-061 OF THE ADMINISTRATIVE CODE AND 42 CFR SECTION 435.1009.

HCFA-179 # 97-19 Date Rec'd
Supercedes 89-21 Date Appr. OCT 31 1997
State Plan Im. JH Date Eff. 7/1/97

(8) "NF TRANSFER" HAS THE SAME MEANING AS STATED IN RULE 5101: 3-3-151 OF THE ADMINISTRATIVE CODE.

(9) "OCCUPIED DAY" IS A DAY DURING THE STAY OF A RESIDENT APPROVED FOR MEDICAID VENDOR PAYMENT FOR WHICH A FACILITY SHALL RECEIVE THE FULL PER RESIDENT PER DAY PAYMENT DIRECTLY FROM MEDICAID IN ACCORDANCE WITH CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE.

(10) "READMISSION" MEANS THE RESIDENT IS READMITTED TO THE SAME NF FOLLOWING A STAY IN A HOSPITAL TO WHICH THE RESIDENT WAS SENT TO RECEIVE CARE OR RETURNS AFTER A THERAPEUTIC PROGRAM OR VISIT WITH FRIENDS OR RELATIVES.

(11) "SKILLED NURSING FACILITY (SNF) MEANS A NURSING HOME CERTIFIED TO PARTICIPATE IN THE MEDICARE PROGRAM.

(B) TO DETERMINE WHETHER SPECIFIC DAYS DURING A RESIDENT'S STAY ARE PAYABLE THROUGH MEDICAID VENDOR PAYMENTS AS BED-HOLD DAYS OR OCCUPIED DAYS, THE FOLLOWING CRITERIA SHALL BE USED:

(1) THE DAY OF ADMISSION COUNTS AS ONE OCCUPIED DAY.

(2) THE DAY OF DISCHARGE IS NOT COUNTED AS EITHER A BED-HOLD OR OCCUPIED DAY.

(3) WHEN ADMISSION AND DISCHARGE OCCUR ON THE SAME DAY, THE DAY IS CONSIDERED AS A DAY OF ADMISSION AND COUNTS AS ONE OCCUPIED DAY, EVEN IF THE DAY IS LESS THAN EIGHT HOURS.

(4) A PART OF A DAY IN THE FACILITY IF GREATER THAN EIGHT HOURS COUNTS AS ONE OCCUPIED DAY FOR REIMBURSEMENT PURPOSES. A DAY BEGINS AT MIDNIGHT AND ENDS TWENTY-FOUR HOURS LATER.

(a) AN INDIVIDUAL WHO LEAVES THE FACILITY TO BE HOSPITALIZED ON MONDAY AT SEVEN A.M. AND RETURNS TO THE FACILITY ON FRIDAY AT TWO P.M. HAS ACCUMULATED FOUR BED-HOLD DAYS (MONDAY-THURSDAY). MONDAY IS COUNTED AS A BED-HOLD DAY, IN THIS EXAMPLE, SINCE THE INDIVIDUAL WAS IN THE FACILITY LESS THAN EIGHT HOURS.

(b) IF THE INDIVIDUAL LEFT THE FACILITY ON MONDAY AT NINE A.M. AND RETURNED ON FRIDAY AT TWO P.M., THREE BED-HOLD DAYS HAVE BEEN ACCUMULATED (TUESDAY-THURSDAY) SINCE THE INDIVIDUAL WAS IN THE FACILITY FOR MORE THAN EIGHT HOURS ON BOTH MONDAY AND FRIDAY WHICH ARE COUNTED AS OCCUPIED DAYS (SEE APPENDIX A OF THIS RULE).

(C) FOR MEDICAID-ELIGIBLE RESIDENTS IN CERTIFIED NFS, EXCEPT THOSE DESCRIBED IN PARAGRAPH (H) OF THIS RULE, ODHS MAY PAY THE NF TO RESERVE A BED ONLY FOR AS LONG AS THE RESIDENT INTENDS TO RETURN TO THE FACILITY BUT FOR NOT MORE THAN THIRTY DAYS IN ANY CALENDAR YEAR. REIMBURSEMENT FOR BED-HOLD DAYS SHALL BE PAID AT FIFTY PER CENT OF THE FACILITY'S PER DIEM RATE. THIS REIMBURSEMENT SHALL BE CONSIDERED PAYMENT IN FULL, AND THE NF MAY NOT SEEK SUPPLEMENTAL